



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

04943

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....CecilCity or town.....Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....19 days

Hospital, Institution, or street address where death occurred:

Union HospitalHow long in hospital or institution?.....19 days

3. (a) FULL NAME

Florence Ann Blake4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife.....J. Frank Blake, Sr.
Childs, Md.7. Birth date of deceased (mo., day, yr.) September 7, 18668. AGE: Years 80 Months 9 Days 11 It less than one day hrs. min.9. Birthplace.....Carroll County, Md.
(Town, county, and state)10. Usual occupation.....Housewife

11. Industry or business

12. Name.....John Burke13. Birthplace.....Cecil County, Md.14. Maiden name.....Annie Howard15. Birthplace.....England16. Informant.....Daughter Emily CameronAddress.....Rising Sun, Md17. Burial..... Date thereof June 21, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Leeds - MethodistLocation.....Leeds, Md.18. Funeral director.....H. W. Poppin & Son, M.C. LucyAddress.....Elkton, Md.19. June 19, 1947
(Date rec'd by registrar)J. H. Frazer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....CecilCity or town.....Childs
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....June 18, 1947 19..... at 1:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1947, 19..... to June 18, 1947, 19.....and that I last saw her.....alive on June 18, 1947, 19.....

Immediate cause of death.....

Carcinoma of small bowel with
obstruction

DURATION

3 yrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

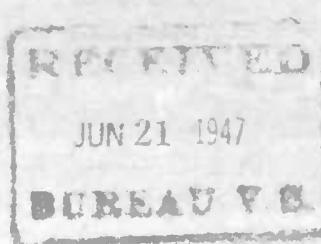
Means of injury

Injured at work?

23. SIGNATURE.....J. H. Frazer

M. D. or other

Address.....Elkton, Md. Date signed.....June 18, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04944

CERTIFICATE OF DEATH

183
Reg. Dist. No. 96

1. PLACE OF DEATH:

County..... *near Charleston*
City or town..... *near Charleston*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... *about 3 months*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Arthur Bertram Bonner

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife..... *Nellie Bonner*

7. Birth date of

deceased (mo., day, yr.) *Dec. 3 - 1876*6.(c) If alive, give age..... *61* years

8. AGE:

Years
*70*Months
*6*Days
*9*If less than one day
hrs. min.

8. Birthplace.....

London, England

(Town, county, and state)

10. Usual occupation.....

Plumber

11. Industry or business

12. Name..... *James Bonner*13. Birthplace..... *England*14. Maiden name..... *Unknown*

15. Birthplace.....

16. Informant..... *Mrs. Nellie Bonner (wife)*Address..... *Carpenters Point, Calvert Co. Md.*17. (Burial, cremation, or removal. Which?) *Cremation* Date thereof..... *6/16/47*
(month) (day) (year)Cemetery or crematory..... *Greenmount Cemetery*Location..... *Greenmount Ave & Olive, Baltimore, Md.*18. Funeral director..... *Pennington & Son*Address..... *Hardey Street, Md.*19. *John* 16 1947 *Dave E. Daugherty*
(Date rec'd by registrar) *Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Maryland* County..... *Calvert*City or town..... *near Charleston*
(If outside city or town limits, write RURAL and give nearest town)Street No..... *Carpenters Point*
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... *June 12* 1947 at *2:06 p.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him *dead* alive on *June 12* 1947

Immediate cause of death.....

Accidental drowning

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... *Accident* Date of..... *June 12, 1947*Where did injury occur? *Carpenters Point, Calvert Co., Md.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *Public Place* —Means of injury *Drowning in river* Injured at work? *No*23. SIGNATURE..... *Donald H. Sprecher, M.D.* M. D. or otherAddress..... *Elkton, Md.* Date signed *June 12, 1947*

RECEIVED

JUN 17 1947

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04945

94

CERTIFICATE OF DEATH

131a
Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Cecil

City or town.....

North East

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

15

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

M
JUZANNA DeMONDE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife.....

Joseph Heater DeMonde

7. Birth date of deceased (mo., day, yr.)

Aug 11 1871

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

75 10 - hrs. min.

9. Birthplace.....

North East (Post) Cecil Co., Md

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

Leslie Md

FATHER

12. Name.....

J. Wesley Hamerton

13. Birthplace

Leslie Md

MOTHER

14. Maiden name.....

Ann Marie Mullen

15. Birthplace

Leslie Md

16. Informant.....

Mrs. Tetta Cameron

Address

North East Md

17. (Burial, cremation, or removal. Which?)

Burial Date thereof.....

June 19-1947

(month) (day) (year)

Cemetery or crematory.....

Methodist

Location.....

North East Md

18. Funeral director.....

Joseph P. Tracy

Address

North East Md

19. 6-15-1947

Leda & Circus

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Cecil

City or town.....

North East

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 11 1947 at 105pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 27 1947 to June 11 1947

and that I last saw her alive on June 9 1947

Immediate cause of death.....

Uremic poisoning

DURATION

3 days

Due to..... chronic interstitial nephritis

3 days

Due to.....

Gastritis and gall-bladder

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

James L. Johnson M.D.

M. D. or other

Address..... 212 E. High St., Ellicott, Md. Date signed 6/14/47.

RECEIVED BY THE STAFF OF THE
BUREAU OF INVESTIGATION

RECEIVED BY THE STAFF OF THE
BUREAU OF INVESTIGATION

RECEIVED

JUN 18 1947

BUREAU V.B.



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04946

468

CERTIFICATE OF DEATH

Reg. Dist. No. 95

1. PLACE OF DEATH:

County Clermont Co.

City or town Rising Sun, rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Arthur Eller

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Ray Eller

7. Birth date of deceased (mo., day, yr.)

Nov. 11 - 1883

6. (c) If alive, give age 42 years

8. AGE:

Years 74 Months 7 Days 13 If less than one day

hrs.

min.

9. Birthplace

Clermont Co. North Carolina

(Town, county, and state)

10. Usual occupation

Laborer on Farm

11. Industry or business

Calvin Eller

12. Name

Calvin Eller

13. Birthplace

N. C.

14. Maiden name

Unknown

15. Birthplace

N. C.

16. Informant

Harley Eller

Address

Rising Sun, Md., R. F. D.

17. Burial

Date thereof July 1, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Baptist Cem

Location

Circleville, Md.

18. Funeral director

J. E. Tyson

Address

Rising Sun, Md.

19. (Dated and signed by registrar)

Date June 30, 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil Co. Md.

City or town Rising Sun, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

June 26, 1947, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 26, 1947, to June 28, 1947, and that I last saw him alive on June 26, 1947.

Immediate cause of death

Cancer of stomach

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

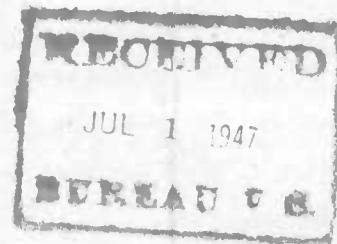
Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1318

04947

92

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Cecil
 City or town Eck Mills
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James Roy Forester

4. Sex

5. Color or race white
 Male married

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife Mary Forester7. Birth date of
deceased (mo., day, yr.)Oct 1 1879

60 years

8. AGE:

| | | | |
|-----------------|-----------------|----------------|---|
| Years <u>67</u> | Months <u>8</u> | Days <u>12</u> | If less than one day Jrs. <u> </u> min. <u> </u> |
|-----------------|-----------------|----------------|---|

9. Birthplace

Mountain City Tenn

(Town, county, and state)

10. Usual occupation

Marley Paper mill

11. Industry or business

Calvin Forester

12. Name

North Carolina

13. Birthplace

no information

14. Maiden name

Mountain City Tenn

15. Birthplace

Mary Forester

16. Informant

Eck Mills Md

Address

Burial

(Burial, cremation, or removal. Which?)

Eckton Cemetery

Cemetery or crematory

Eckton Md

Location

24 W. Main

18. Funeral director

John F. Rogers

Address

Eckton Md

19. Date rec'd by registrar

June 16 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Eck Mills (If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

115-10-5627

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 13 1947 at 7:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 10 1947 to June 13 1947and that I last saw him alive on June 12 1947

Immediate cause of death

Cardiac Insufficiency

DURATION

3 yrs

Due to

Due to

Other conditions Ch. perniciousneuritis

(Include pregnancy within 3 months of death)

Major findings or operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

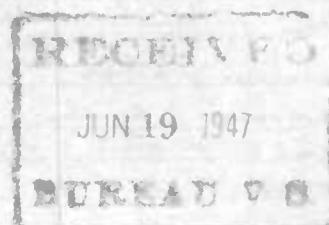
Means of injury _____ Injured at work? _____

23. SIGNATURE James L. Johnson M.D. M. D. or otherAddress Eckton Md Date signed 6/16/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04948

CERTIFICATE OF DEATH

183 CB Reg. Dist. No. 90

1. PLACE OF DEATH:

County

Esmelle Russell

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: not today

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert Lewis Graham

4. Sex

5. Color or race

8. (a) Single, married, widowed, or divorced

Male White Single

6. (b) Name of husband or wife

T. Birth date of deceased (mo., day, year) 6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Wilmington Del.

(Town, county and state)

10. Usual occupation

City Foreman

11. Industry or business

Robert Graham

Wilmington Del.

Virginia Speaker

Wilmington Del.

Bernard N. Lorn

Address 2921 Pattnall St. WilDel

17. Burial Date thereof

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory ~~Co. the cathedral~~ Riverview

Location Wilmington Dela

18. Funeral director ~~6~~ ~~deod~~ Bellour

Address Wilmington Md

19. Registrar Mr. Harry W. Cherry

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Wilmington County New Castle

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

2921 Pattnall

(If rural, give LOCATION)

2.(a) If veteran, name war

World War II

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 29 1947 11 10

19. to 19.

and that I last saw him alive on

Immediate cause of death

Overdosed.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

6/28-47 Date of

White Crystal May 16 1947 (City or town) (County) (State)

Injured at home, farm, industry, public place (Month)

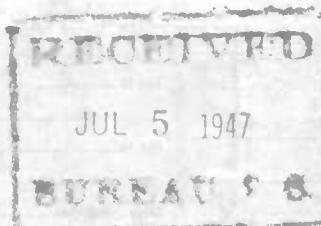
Muscle cramp Injured at work? Medical Examiner

Cecil County

23. SIGNATURE

V. D. or other Date signed

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

04949

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

Cecil

Elkton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Union Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md. County

Cecil

Rising Sun Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Grace Eva Hale Harrington

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife

Arnold Bradford Harrington

7. Birth date of deceased (mo., day, yr.)

Aug. 31. 1894

6. (c) If alive, give age 51 years

8. AGE:

| | | | |
|-------|--------|------|----------------------|
| Years | Months | Days | It less than one day |
| 52 | 9 | 24 | hrs. min. |

9. Birthplace

Corners Rock, Va.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name Fletcher Hale

13. Birthplace Corners Rock, Va.

14. Maiden name

Sarah Wynn

15. Birthplace Corners Rock, Va.

16. Informant

Hilma Harrington

Address

Rising Sun, Md. R. R. 2

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 28 1947

(month) (day) (year)

Cemetery or crematory

Hagerstown

Location

Near Post Deposit, Md.

18. Funeral director

J. E. Lyon

Address

Rising Sun, Md.

19. Date rec'd by registrar

June 26 1947

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

25 June 1947 at 9:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1946 to 25 June 1947

and that I last saw her alive on 25 June 1947

Immediate cause of death

Kremeria

DURATION

4 weeks

Due to Malignant Nephrosclerosis

Due to

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

Hans H. Huebner M.D.

M. D. or other

Address North East, Md.

Date signed 26 June 47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157e

04950 95

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Cecil

City or town.....

Rowlandsville

(If outside city or town limits, write RURAL and give nearest town)

3 days

How long in above place of death?

Hospital, institution, or street address where death occurred

Now long in hospital or institution?

3. (a) FULL NAME

4. Sex:

Male

5. Color of race:

White

6. (a) Single, married, widowed, or divorced

S -

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

June 27 - 1947.

6. (c) If alive, give age.....

years

8. AGE: Years

Months

Days

If less than one day

3.hrs.min.

9. Birthplace.....

Rowlandsville, Md.

(Town, county, and state)

10. Usual occupation.....

None

11. Industry or business

None

12. Name.....

Hugh Harry

13. Birthplace

Rock Springs

14. Maiden name.....

Josephine Gerhard

15. Birthplace

Baltimore, Md.

16. Informant.....

Hugh & Harry

Address

Rowlandsville, Md.

17. Burial.....

July 2, 1947

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Little Britton, Pa.

Location

Chester Co., Penna

18. Funeral director

H. S. Bailey

Address

10 Arlington, Md.

19. (Date rec'd by registrar)

June 30-47

L. M. Washington

Registrar

6-30-47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

City or town..... Rowlandsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

No

3. (b) Social Security Number

Mr

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

June 30 1947 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

June 27 1947 to June 29 1947

and that last saw h. m. alive on June 29 1947

Immediate cause of death.....

Congenital Defects
Blue Baby

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

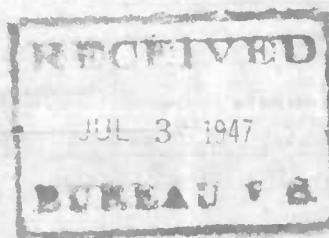
Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Port Deposit, Md. Date signed 7/1/47

Comments.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

04951

95

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town..... *Rising Sun* Rural.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *15 years*

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Brown Janney Jr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

Single

6. (b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.) *Dec 4, 1931*

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state) *Rising Sun, Md.*

10. Usual occupation.....

School boy.

11. Industry or business.....

12. Name..... *Brown Janney*

13. Birthplace.....

Va.

14. Maiden name.....

Rosie Underwood

15. Birthplace.....

Va.

16. Informant.....

Mrs. Rosie Harrington

Address.....

Rising Sun, Md. P. R. R. O.

17. Burial.....

Date thereof: June 18, 1947

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory..... *Burial*Location..... *Rising Sun, Md.*

18. Funeral director.....

Address..... *Rising Sun, Md.*

19. (Date rec'd by registrar)

Date signed *June 17, 1947*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County..... *Cecil*

City or town.....

Rising Sun, Md. Rural.

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 15, 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

19.....

Immediate cause of death.....

*Uremia.
Cerebral
nephritis*

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE

Medical Examiner

All Credit COUNTRY

M. D. or other

Address.....

Date signed *June 17, 1947*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04952

55a

Rec
Reg. Dist. No. 96

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Cecil
City or town..... Perry Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 years

Hospital, Institution, or street address where death occurred:

VAH, Perry Point, Md.

How long in hospital or institution?..... VAH, Oteen, N.C. 7-13-37 to

4-8-43

3. (a) FULL NAME

Oscar W. Johnson

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced

Male..... White..... Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)..... April 10, 1888
8. AGE: Years..... Months..... Days..... If less than one day

59..... 2..... 8..... hrs..... min.

9. Birthplace..... Sweden

(Town, county, and state)

10. Usual occupation..... Cook

11. Industry or business

FATHER 12. Name..... Unknown

13. Birthplace..... Unknown

MOTHER 14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant..... Hospital Records

Address..... VAH, Perry Point, Md.

17. Removal.....

(Burial, cremation, or removal. Which?)..... Date thereof.....

(month) (day) (year)..... 6/21/47

Cemetery or crematory..... Baltimore National Cemetery

Location..... Baltimore, Maryland

18. Funeral director..... Pennington & Son

Address..... Havre de Grace, Maryland

19. June 21 1947 Irene E. Daugherty

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No..... 2813 W. Lanvale Street

(If rural, give LOCATION)

2.(a) If veteran, name war..... World War I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18 1947 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1945, to June 18, 1947.

and that I last saw him alive on June 18, 1947.

Immediate cause of death

Tuberculosis pulmonary, chronic, active, far advanced

DURATION

5 years

Due to

Due to

Other conditions..... Adenocarcinoma, left suprarenal Unkn. gland with metastasis, liver, lungs and kidneys (Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ---

Autopsy results..... Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of ---

Where did injury occur?..... (City or town)..... (County)..... (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work? ---

23. SIGNATURE..... A.E. TROLLINGER, M.D., Clin. Director

Address..... VAH, Perry Point, Md. Date signed 6-18-47

RECEIVED

JUN 24 1947

STRENGTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. (No. 1992)

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

E. Main St.

How long in hospital or institution?

3. (a) FULL NAME

4. Sex:

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: 50

(c) If alive, give age

8. AGE: Years

Months

Days

If less than one day

.hrs. min.

9. Birthplace.....

(Town, County, and state)

10. Usual occupation.....

11. Industry or business

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 3 1947 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death.....

Acute coronary thrombosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Medical Examiner

Cecil County

M. D. or other

Date signed

RECEIVED

JUN 9 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04354

CERTIFICATE OF DEATH

92-
Reg. Dist. No. 92

1. PLACE OF DEATH:

Cecil
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

8 Hrs.

Hospital, Institution, or street address where death occurred:

Union Hospital

How long in hospital or institution?.....

8 Hrs.

3. (a) FULL NAME

Ogoretta F. Lewis

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife..... James L. Lewis7. Birth date of deceased (mo., day, yr.) August 26, 19066. (c) If alive, give age 43 years8. AGE: 40 Years 9 Months 13 Days It less than one day9. Birthplace Harrisonburg, Rockingham Co., Va.

(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name Samuel McCrary13. Birthplace Va.14. Maiden name Mary M. Life15. Birthplace Va.16. Informant James L. LewisAddress Charlestown, Md.17. Burial Charlestown Date thereof June 10, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Location Charlestown, Cecil Co., Md.18. Funeral director Lee A. Patterson & SonAddress Perryville, Md.19. June 9, 1947 (Date rec'd by registrar)H. F. Fraser

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 June 1947 at 8 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 June (M) 1947, 10. 6 June 1947and that I last saw her alive on 7 June 1947.Immediate cause of death CARDIAC FAILURE

DURATION

Due to MITRAL STENOSISDue to RHEUMATIC HEART DISEASE

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

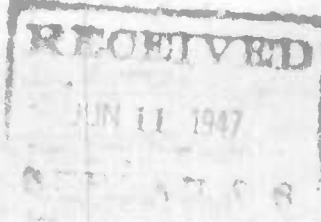
Means of injury

Injured at work?

23. SIGNATURE J. H. Sadowsky MD

M. D. or other

Address Perryville, Md. Date signed 8 June 47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04955

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 91

M

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Cecil
 County: Chesapeake City
 City or town: Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 years
 Hospital, Institution, or street address where death occurred: Chesapeake City
 How long in hospital or institution?

3. (a) FULL NAME Harry K Morgan

4. Sex M. 5. Color or race wh 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo. day, yr.) April 14 1868 6. (c) If alive, give age: years

8. AGE: 79 Years 1 Months 13 Days If less than one day hrs. min.

9. Birthplace: Chesapeake City
 (Town, county, and state) Maryland

10. Usual occupation: Rehd Farmer

11. Industry or business

12. Name: Charles Morgan
 Father: Maryland

Mother: Rebecca Robinson
 13. Birthplace: Maryland

14. Maiden name:
 15. Birthplace: Maryland

16. Informant: Mrs. Lydia Morgan
 Address: Chesapeake City, Md

17. Burial: Bethel
 (Burial, cremation, or removal. Which?) Cemetery or crematory: Bethel
 Location: near Chesapeake City, Md

18. Funeral director: H.W. Chapman
 Address: Elkton, Md

19. Date rec'd by registrar: June 4th 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Md. County: Cecil
 City or town: Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)

Street No.:
 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1947 to June 1 1947 and that I last saw him alive on May 31 1947

Immediate cause of death:

coronary occlusion

DURATION

7 hoursDue to: Coronary SclerosisunknownDue to: Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.: Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of: Where did injury occur? (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury: Injured at work? 23. SIGNATURE: H. V. Davis, M.D.

M. D. or other

Address: 116 W. Chestnut St. Date signed: 6/14/47

RECEIVED

JUN 5 1947

BUREAU of INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

96

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-4-5-15M

1. PLACE OF DEATH:

County..... CecilCity or town..... Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 1 mos. 11 days

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.How long in hospital or institution? Since July 14, 1943

3. (a) FULL NAME

O'DONNELL, Anna E.

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Feb. 16, 1861

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

86

3

22

hrs.

min.

9. Birthplace..... New York State

(Town, county, and state)

10. Usual occupation.....

Nurse

11. Industry or business

12. Name..... Unknown13. Birthplace..... Unknown14. Maiden name..... Unknown15. Birthplace..... Unknown16. Informant..... Hospital Records

Address

17. Removal

(Burial, cremation, or removal. Which?)

Date thereof..... June 9, 1947

(month) (day) (year)

Cemetery or crematory..... UnknownLocation..... Saugeties, New York18. Funeral director..... PENNINGTON & SONAddress..... Havre de Grace, Maryland

19. June 9, 1947

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Pennsylvania

County

City or town..... Rosemont

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Rosemont College

(If rural, give LOCATION)

2.(a) If veteran, name war..... Spanish American

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 8, 1947 at 12:02 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27, 1945 to June 8, 1947and that I last saw h. im. alive on June 8, 1947

Immediate cause of death.....

Pneumonia, left lower lobe

DURATION

21 daysDue to..... Hypertensive cardiovascular disease; Hypertension, generalized

Unknown

Due to.....

Other conditions..... Pneumococcal infectionPericarditis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

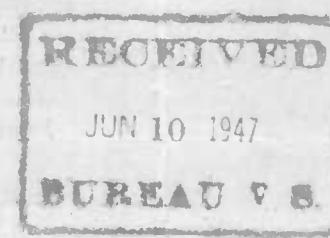
Injured at work?

33. SIGNATURE

A. E. TROLLINGER, M.D., Clinical Director

M.D. or other

Address..... VAH, Perry Point, Md. Date signed..... 6-8-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ~~the~~ is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183

04957

CERTIFICATE OF DEATH

Reg. Dist. No. 90

1. PLACE OF DEATH:

County.....

City or town.....

Edgar
Breckinridge

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Horace Thomas. O'Fwelle

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Fannie B. O'Fwelle

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 3, 1907

Years

40

Months

Days

It less than one day

hrs. min.

9. Birthplace

Delaware (Town, county and state)

10. Usual occupation

Painter

11. Industry or business

Horley O'Fwelle

12. Name

Fannie B. O'Fwelle

13. Birthplace

Delaware

14. Maiden name

Sadiq King

15. Birthplace

Delaware

16. Informant

Fannie B. O'Fwelle

Address

Burial Galena Md.

17. (Burial, cremation, or removal. Which?)

Date thereof June 13, 1947

(month) (day) (year)

Date of

injury

Cause

Date

Cemetery or crematory

Galena

Place

Location

Galena Md.

18. Funeral director

Edgar O'Fwelle

Address

Millington Md.

19. (Date rec'd by registrar)

June 12 1947 Mrs. Horace O'Fwelle

Address

20. (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

Md. Galena Kent

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

214-03-0030

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10 1947 at 12 $\frac{1}{2}$ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on dead June 10 1947

Immediate cause of death.....

Accidental drowning

Due to.....

Duo to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

injury

Cause

Date

Where did injury occur?.....

(City or town)

County

State

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE

Dr. Edward K. Fletcher, M.D. or other

Address.....

Date signed June 10, 1947

RECEIVED

JUN 14 1947

FBI - BOSTON

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

168

04958

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH

County

Harmoned Beach Club

City or town (If outside city or town limits, write RURAL and give nearest town)

30 minutes

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Michael L. Peterson

4. Sex M. 5. Color or race Wh. 6. (a) Single, married, widowed, or divorced Married.

8. (b) Name of husband or wife Rachel Peterson

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1906 8. (c) If alive, give age 37 years

8. AGE: Years 40 Months 7 Days 27 If less than one day hrs. min.

9. Birthplace Elkton, Md. (Town, county, and state)

10. Usual occupation Barber

11. Industry or business

John Peterson

12. Name John Peterson

13. Birthplace Austin

14. Maiden name Mamie Cava

15. Birthplace Brooklyn

16. Informant Mr. William Peterson

Address Elkton, Md.

17. Burial Burial Date thereof June 28/47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Elkton

Location Elkton, Md.

18. Funeral director Hot Pipper

Address Elkton, Md.

19. June 26 19. 47 (Date rec'd by registrar) 20. (Date of death) 21. (Date of death)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Elkton, Rural

City or town (If outside city or town limits, write RURAL and give nearest town)

Surgery Road.

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

214-20-2028

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1947, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw h. alive on 19.

Immediate cause of death

Harmoned Beach Club at time of drowning

Due to

Nickel under foot

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

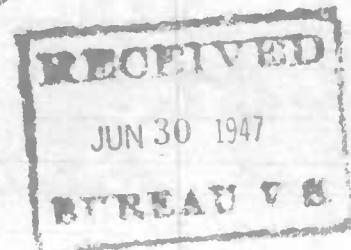
Autopsy results

Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Harmoned Beach Club Date of 6/22/47Where did injury occur? Elkton, Cecil Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where) Harmoned Beach ClubMeans of injury Nickel under foot Injured at work?Medical Examiner Elkton, Cecil County M. D. or other23. SIGNATURE R. R. Fraser Date signed 6/23/47Address Elkton, Cecil County



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04959

93

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

Port Deposit, rural.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Adrianna Elizabeth Pierce.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

married

6. (b) Name of husband or wife

Sott Pierce.

7. Birth date of deceased (mo., day, yr.)

Dec. 17, 1895

6. (c) If alive, give age..... 51 years

8. AGE:

Years

Months

Days

if less than one day

51

5-

1-

hrs.

min.

9. Birthplace.....

Colora. Cecil Co. 3rd.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

William Phily. J. Phelps.

12. Name.....

Germany

13. Birthplace

Catherine McClairgen

14. Maiden name.....

Penns.

15. Birthplace

Mr. Sott Pierce

16. Informant.....

Port Deposit, Md.

Address

Burial Date thereof June 5, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

17. Cemetery or crematory

Brookview

Location

Rising Sun, Md.

18. Funeral director

J. E. Tyson

Address

Rising Sun, Md.

19. Date record by registrar

June 4, 1947

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Cecil

City or town..... Port Deposit, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6-2

1947, at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-1 1947, to 6-2 1947

and that I last saw h.e. alive on 6-2 1947

Immediate cause of death

Pulmonary Embolism

DURATION

Due to

Cerebral Thrombosis 11-2-46

Due to

Chronic Myositis 5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M.D. or other

Address

Port Deposit, Md. Date signed 6-2-47

RECEIVED

JUN 5 1947

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04960

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County

City or town

Eltton Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Ethelmaud Reed

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife

Wife married
Jesse M Reed7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Henderson, Ind.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Thomas Bradley

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Eltton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 17 1947 at 9:15 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19...

to 19...

and that I last saw h. alive on

19...

Immediate cause of death

Acute coronary
thrombosis.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

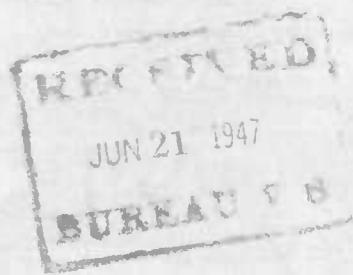
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

Pleasanton, Ind. Medical Examiner
Cecil County
Address: 101 W. Main Street, Room 101, Elkhart, Ind. M. D. or other
Date signed: 6-17-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

04961

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940
Reg. Dist. No.

96

1. PLACE OF DEATH:

County: CecilCity or town: Perry Point, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs, 8 mos, 29 days

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Md.How long in hospital or institution? Unknown

3. (a) FULL NAME

SMITH, Charles F.4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single6. (b) Name of husband or wife ---6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) March 5, 18798. AGE: Years 68 Months 3 Days 19 If less than one day hrs. min.9. Birthplace Ohio
(Town, county, and state)10. Usual occupation Unknown

11. Industry or business

12. Name Robert Smith
13. Birthplace Unknown14. Maiden name Unknown
15. Birthplace Unknown16. Informant Hospital records
Address VAH, Perry Point, Md.17. Removal Baltimore National Cemetery
(Burial, cremation, or removal. Which?) Date thereof, June 27, 1947
(month) (day) (year)Cemetery or crematory Baltimore, Maryland
Location Pennington & Son18. Funeral director Pennington & Son
Address Havre de Grace, Md.19. June 27, 1947 Irene E. Daugherty
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ohio County Co.City or town No permanent home

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1

(If rural, give LOCATION)

2. (a) If veteran, name war WW-I

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

June 24, 1947 at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 25, 1946, to June 24, 1947,

and that I last saw him alive on June 24, 1947.

Immediate cause of death

Hemorrhage, cerebral, subdural

DURATION

2 hrs.Due to Arteriosclerosis, generalized Unknown

Due to:

Other conditions

Coronary arteriosclerosis, severe

Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---Where did injury occur? --- (City or town) --- (County) --- (State)Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE J. E. Healeys M.D. or other

A. E. TROLLINGER, M.D., Clinical Director

VAH, Perry Point, Md. Date signed June 27, 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04962

CERTIFICATE OF DEATH

Reg. Dist. No. 92

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-4-15M

1. PLACE OF DEATH: Cecil
 County: Elkton
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, Institution, or street address where death occurred: Elkton Hospital
 How long in hospital or institution?

3. (a) FULL NAME Vandora Smith

4. Sex Female 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Oct 20 1879 6. (c) If alive, give age..... years

8. AGE: Years 67 Months 7 Days 26 If less than one day
 hrs. min.

9. Birthplace Camden N.J.
 (Town, county, and state)

10. Usual occupation House work

11. Industry or business

12. Name Matthew Smith

13. Birthplace Maryland

14. Maiden name Rachel Ann Gibber

15. Birthplace Maryland (Snow Hill)

16. Informant Ada Carter

Address Chesapeake City Md

17. Burial Burial Date thereof June 19 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bohemian Manor

Location Chesapeake City Md R.D.

18. Funeral director H. W. Simpson

Address Elkton Md

19. June 17 47 (Date rec'd by registrar) 20. June 17 47 (Date signed) F. R. Frazer Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Cecil
 City or town Chesapeake City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1947 to June 15 1947 and that I last saw her alive on June 14 1947

Immediate cause of death Myocardial infarction
artery sclerosis
arteritis Heart disease 2 months

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

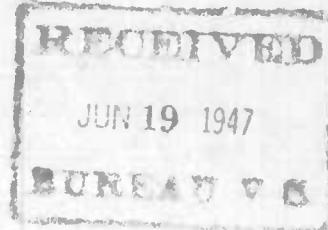
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry Doss M. D. or other

Address Chesapeake Md Date signed 6/14/47



04963

Evidence for the change of MARYLAND STATE DEPARTMENT OF HEALTH

years of birth is shown on

2411 N. Charles St., Baltimore

172

FILM NO. G 11 JUN 27 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 96

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County

City or town

Perryville Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? few hours.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

George Walter Spicer, Jr.

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

White

Married

6. (b) Name of husband or wife

Josephine Eller Spicer

7. Birth date of deceased (mo., day, yr.)

March 14, 1947 1916

6. (c) If alive, give age 28 years

8. AGE: Years

Months

Days

If less than one day

31

2

28

hrs.

min.

9. Birthplace Wilkes Co. North Carolina

(Town, county, and state)

10. Usual occupation Civilian Gunnar

11. Industry or business Aberdeen Proving Ground

12. Name George W. Spicer Sr

13. Birthplace Wilkes Co. North Carolina

14. Maiden name Annie Taylor

15. Birthplace Ash Co. North Carolina

16. Informant George W. Spicer Sr.

Address N. Wilkesborough, North Carolina

17. Burial Date thereof Junel 17 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Oak Grove Cemetery

Location Churchville Harford Co. Md.

18. Funeral director Lee G. Patterson Son

Address Perryville, Md.

19. Jun 17 1947 Date rec'd by registrar

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.

County

Harford

Churchville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

2D. DATE OF DEATH June 12

1947 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw h. alive on

19

Immediate cause of death

Drowned.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur Lapidum Harford. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury fall out of boat (injury at work?)

Medical Examiner

Cecil County

M. D. or other

Date signed 6-16-47

RECEIVED

JUN 19 1947

BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

04964

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH:

County.....

City or town.....

Cecil

Elkton, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

50 years

Hospital, institution, or street address where death occurred:

Elkton

Union Hosp.

How long in hospital or institution?

55 days

3. (a) FULL NAME

William T. Stanley

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M. wh. Widowed.

6.(b) Name of husband or wife

Mary L. Stanley

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

May 25 1860

8. AGE:

Years

Months

Days

If less than one day

87 0 12 hrs. min.

9. Birthplace

New Jersey

(Town, county, and state)

10. Usual occupation

Retail Farmer

11. Industry or business

Andrew Stanley

12. Name

Andrew Stanley

13. Birthplace

New Jersey

14. Maiden name

No Information

15. Birthplace

New Jersey

16. Informant

John S. Aronato

Address

Elkton P.D., Md

17. Burial

Date thereof... June 9, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Elkton

Location

Elkton, Md

18. Funeral director

H.W. Pippin

Address

Elkton, Md

19. June 7, 1947

(Date rec'd by registrar)

F.R. Frazer
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md. County.....

City or town.....

Rural Near Elkton, Md.

Street No.....

P.D., Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1947 19 at 15⁰⁰

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 12 1947 to June 6 1947, and that I last saw him alive on June 5 1947.

Immediate cause of death

Cardiac Failure

Due to... Cardiac - vascular - renal disease.

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings at operation...

Date of op.

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. E. Ford & Son, Inc.

M. D. or other

Address: Elkton, Md. Date signed June 6, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

VS A16 9-45-15M T



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: **Cecil**
 County.....
 City or town..... **Perryville, Md. Rural**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **50 Yrs.**
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?
 3. (a) FULL NAME
Annie Bernice Taylor

| | | | |
|---|---|---|--|
| 4. Sex F | 5. Color or race White | 6. (a) Single, married, widowed, or divorced Married | |
| B. (b) Name of husband or wife Harry Taylor | | | |
| 7. Birth date of deceased (mo., day, yr.) Sept. 16, 1874 | | | |
| 8. AGE: Years 72 | Months 8 | Days 23 | If less than one day hrs. min. |
| 9. Birthplace Port Deposit, Md. Rural (Town, county, and state) House Wife | | | |
| 10. Usual occupation | | | |
| 11. Industry or business | | | |
| FATHER | 12. Name John Jackson | 13. Birthplace Cecil Co., Md. | |
| MOTHER | 14. Maiden name Rosalie Benjamin | 15. Birthplace Cecil Co., Md. | |
| 16. Informant Harry Taylor | | | |
| Address Perryville, Md. Rural. | | | |
| 17. Burial (Burial, cremation, or removal. Which?) Asbury Date thereof June 11, 1947 (month) (day) (year) | | | |
| Location Port Deposit, Md. Rural | | | |
| 18. Funeral director W. A. Patterson & Son Address Perryville, Md. | | | |
| 19. (Date rec'd by registrar) June 11 1947 June 11 1947 Registrar | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04965

466

CERTIFICATE OF DEATH

Reg. Dist. No. **96**2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **Maryland** County **Cecil**
 City or town **Perryville, Md. Rural**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **June 8 1947** at **4:00 P.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June 10 1947** to **June 7 1947**, and that I last saw her **alive** on **June 7 1947**.

Immediate cause of death **Paroxysms of Stomach** **8 mos.**
 DURATION

Due to.....

Due to.....

Other conditions **Ch. Hypocondriac** **5 yrs**
Ch. Endocondriac **5 yrs**
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE **B. Jefferson M.D.** M. D. or other **Port Deposit, Md.** Date signed **6/9/47**

Address.....

RECEIVED

JUN 14 1947

BUREAU OF S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83d

04966

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH:

Cecil

County.....

City or town..... Perry Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 5 mos. 0 days

Hospital, institution, or street address where death occurred:

VAH, Perry Point, Maryland

How long in hospital or institution?

3. (a) FULL NAME

TEUSCHLER, Albert J.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

M W Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 6.(c) If alive, give age..... years

June 8, 1890

8. AGE: Years Months Days It less than one day

56 11 28 hrs. min.

9. Birthplace..... Newark, New Jersey
(Town, county, and state)

10. Usual occupation..... Unknown

11. Industry or business

MOTHER FATHER 12. Name..... Albert Teuschler - deceased

13. Birthplace..... Unknown

MOTHER 14. Maiden name..... Christina - deceased

15. Birthplace..... Unknown

16. Informant..... Hospital Records

Address

17. Removal Date thereof..... 6 - 9 - 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Unknown

Location..... Irvington, New Jersey

18. Funeral director.....

PENNINGTON & SON

Address..... Havre de Grace, Md.

19. Date rec'd by registrar..... June 9, 1947
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... New Jersey County..... Essex

City or town..... Irvington
(If outside city or town limits, write RURAL and give nearest town)Street No..... 9 University Place
(If rural, give LOCATION)

2.(a) If veteran, name war..... WW-I

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 6, 1947, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 6, 1938, to June 6, 1947

and that I last saw him alive on June 6, 1947

Immediate cause of death.....

Gangrene, both stumps (amputation, right leg 10-3-46; amputation, left leg 3-20-47)

Due to..... Arteriosclerosis, general; Arteriosclerosis, cerebral

DURATION

1 Month

Over 10 yrs

Due to.....

Other conditions..... Left hemiplegia

Decubitus, sacral area
(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

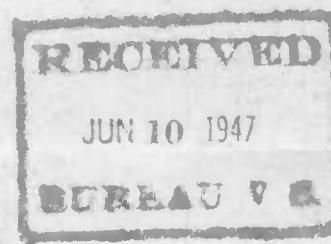
23. SIGNATURE

A. E. TROLLINGER, M.D., Clinical Director
Address..... Perry Point, Md.

M. D. or other

Date signed

6-7-47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

9408

CERTIFICATE OF DEATH

Reg. Dist. No. 049687

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County.....

Cecil

City or town..... Chesapeake City, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

16 yrs

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Thomas Wilson

Walton

3. (b) Social Security Number

169-20-1604

4. Sex

Male white married

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.....

Sue R. Walton

6. (c) If alive, give age 39 years

7. Birth date of

deceased (mo., day, yr.)

Nov. 19- 1895

8. AGE:

Years

Months

Days

If less than one day

51

6

18

. hrs. . min.

9. Birthplace.....

Buckingham Co., Virginia

(Town, county, and state)

10. Usual occupation.....

Senior Electrician

11. Industry or business.....

U. S. Floor

12. Name.....

Benjamin Walton

13. Birthplace.....

Virginia

14. Maiden name.....

Myrtle Long

15. Birthplace.....

Virginia

16. Informant.....

Mrs. Thomas W. Walton

Address

Chesapeake City, Md.

17. Burial

Date thereof: July 4-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Bethel

Location.....

Chesapeake City, Md.

18. Funeral director.....

Joseph P. Shaw

Address

North Eng. Rd.

19. Date rec'd by registrar

1947

1947

1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md

County..... Cecil

City or town..... Chesapeake City

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war..... Not a Veteran

MEDICAL CERTIFICATION

20. DATE OF DEATH

June 1 1947 at 7¹⁰ P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

May 16 1947 to June 1 1947

and that I last saw him alive on June 1 1947

Immediately cause of death.....

Coronary thrombosis

DURATION

2 hours

Due to.....

Coronary sclerosis

2 weeks

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

Henry Davis M.D.

M. D. or other

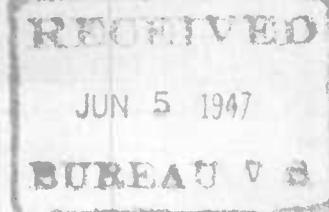
Address..... Chesapeake City, Md. Date signed 6/1/47

1130 afternoons
2 P.M. 957

Ann & H.

Friends may call
from 2 P.M.

1947
C-1000-2
57



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04968

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 90

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH: Cecilton
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME Martha J. Walla
4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) Sept. 10/18 34 8. (c) If alive, give age..... years8. AGE: 92 Years 0 Months 0 Days 0 If less than one day 0 hrs. 0 m.9. Birthplace Maryland (Town, county, and state)10. Usual occupation Housework11. Industry or business Henry Piecer

| | | |
|---------------|----------------|---------------------|
| MOTHER FATHER | 12. Name..... | <u>Henry Piecer</u> |
| | 13. Birthplace | <u>Maryland</u> |

| | | |
|--------|----------------------|--------------------------|
| MOTHER | 14. Maiden name..... | <u>Millington Morgan</u> |
| | 15. Birthplace | <u>Maryland</u> |

16. Informant Mrs Julian P. RobinsonAddress Cecilton Md.17. Burial Burial Date thereof June 4, 1947
(Burial, cremation, or removal which) Date thereof (month) (day) (year)Cemetery or crematory CeciltonLocation Cecilton Md.18. Funeral director Edward FellowAddress Mallington Md.19. June 4 1947 McGraw W. Cheever
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State MD County CeciltonCity or town Cecilton (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 June 1947 at 1:10 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

25 April 1947 to 2 June 1947and that I last saw h. alive on 1 June 1947Immediate cause of death myocardial failureDue to Chronic myocarditis

DURATION

7 days

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. _____

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE Allan R. Cimberly M.D. M. D. or otherAddress McClellan Park Date signed 2 June 1947

255
250
20.
25
360
35

